IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
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BUREAU OF FACILITY STANDARDS
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July 20, 2010

Kathy Prophet
Preferred Community Homes - Mallard
7091 West Emerald Street
Boise, ID 83704

RE: Preferred Community Homes - Mallard, provider #13G032

Dear Ms. Prophet:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Mallard, which was conducted on July 15, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **August 1, 2010,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by August I, 2010. If a request for informal dispute resolution is received after August 1, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

M. Nielsen

MONICA NIELSEN
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MN/srp

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G032	A. BUILDING _____ B. WING _____	07/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - MALLARD	699 SOUTH OTTER MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Monica Nielsen, QMRP Common abbreviations/symbols used in this report are: BSP - Behavior Support Plan HRC - Human Rights Committee PCLP - Person Centered Lifestyle Plan	W 000	"Preparation and implementation of this plan of correction does not constitute admission or agreement by Mallard Landing with the facts, findings or other statements as alleged by the state agency dated July 15th, 2010. Submission of this plan of correction is required by law and does not evidence the truth of any or some of the findings as stated by the survey agency. Mallard Landing – Preferred Community Homes, specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action."	
W 230	483.440(c)(4)(ii) INDIVIDUAL PROGRAM PLAN The objectives of the individual program plan must be assigned projected completion dates. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to assign individualized projected completion dates to objectives for 3 of 3 individuals (Individuals #1 - #3) whose PCLPs were reviewed. This resulted in the potential for individuals to receive training on objectives for extended periods of time without their rate of learning, strengths, and abilities being taken into consideration. The findings include: 1. Individual #3's PCLP, dated 10/20/09, documented a 56 year old male diagnosed with severe mental retardation and anxiety disorder with obsessive compulsive features. None of the objectives in his PCLP contained projected completion dates. When asked, the Administrator stated during an interview on 7/15/10 from 9:00 - 10:00 a.m., completion dates	W 230	**W 230 483.440(c)(4)(ii) INDIVIDUAL PROGRAM PLAN** Objectives for Individual #3's PCLP plan have been assigned projected completion dates. In addition individual # 1 and 2's objectives have been individualized. All individuals projected completion dates have been reviewed to assure they are present and individualized to each individual. Completed by 8-13-2010 Monitored- Monthly Person Responsible- QIDP RECEIVED AUG 0 2 2010 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Kathy Prophet | Administrator | 7-30-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 230	Continued From page 1 needed to be added to his objectives. 2. Individual #1's PCLP, dated 8/10/09, documented a 60 year old male diagnosed with severe mental retardation and anxiety disorder with obsessive compulsive features. All of the objectives in Individual #1's PCLP showed the projected completion dates were set one year from the PCLP date. Individual #1's record did not include documentation that the difficulty of the tasks or his strengths, abilities, rate of learning, and diagnoses were taken into consideration when establishing the 12 month time frame. When asked about the objectives, the Administrator stated during an interview on 7/15/10 from 9:00 - 10:00 a.m., the completion dates needed to be revised and individualized. 3. Individual #2's PCLP, dated 9/17/09, documented a 33 year old male diagnosed with moderate mental retardation, intermittent explosive disorder, and adjustment disorder with depression. All of the objectives in Individual #2's PCLP showed the projected completion dates were set one year from the PCLP dates. Individual #2's record did not include documentation that the difficulty of the tasks or his strengths, abilities, rate of learning, and diagnoses were taken into consideration when establishing the 12 month time frames. When asked about the objectives, the Administrator stated during an interview on 7/15/10 from 9:00 - 10:00 a.m., the completion	W 230		

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W 230	Continued From page 2 dates needed to be revised and individualized. The facility failed to ensure the projected completion dates for Individuals #1 - #3's objectives were present and individualized.	W 230		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the human rights committee for 1 of 3 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted in a lack of protection of individual's rights through prior approvals of restrictive interventions. The findings include: 1. Individual #1's PCLP, dated 8/10/09, documented a 60 year old male diagnosed with severe mental retardation and anxiety disorder with obsessive compulsive features. Individual #1's BSP, dated 4/7/10, documented a bite release restraint could be used if he engaged in biting his hands. However, his record did not contain evidence of approval from the facility's human rights committee for the use of the restraint. When asked, the Administrator stated during an	W 262	**W 262 483.440(f)(3)(i) PROGRAM MONITORING & CHANGE** HRC approval has been obtained for individual #1's restraint for Mandt Bite Release. All individual's consents will be reviewed to ensure that all consents have received HRC approval and that consents match Behavior management plans. All individual's consents along with Behavior Management plans will now be reviewed quarterly in core team meetings. Completed by 8-4-2010 Monitored- Quarterly Person Responsible- QIDP	

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W 262	Continued From page 3 interview on 7/15/10 from 9:00 - 10:00 a.m., the restraint had been used and approval had not been obtained due to an oversight. The facility failed to ensure HRC approval for Individual #1's restraint was obtained prior to its use. Repeat Deficiency.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure restrictive interventions were implemented only with the written informed consent of the legal guardian for 1 of 3 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior approval of a restrictive intervention. The findings include: 1. Individual #1's PCLP, dated 8/10/09, documented a 60 year old male diagnosed with severe mental retardation and anxiety disorder with obsessive compulsive features. Individual #1's BSP, dated 4/7/10, documented a bite release restraint could be used if he engaged in biting his hands. However, his record did not contain evidence of consent from Individual #1's legal guardian for the use of the restraint.	W 263	**W 263 483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE** Guardian approval has been obtained for individual #1's restraint for Mandt Bite Release. All individual's consents will be reviewed to ensure that all consents have received Guardian approval and that consents match Behavior management plans. All individual's consents along with Behavior Management plans will now be reviewed quarterly in core team meetings. Completed by 8-4-2010 Monitored- Quarterly Person Responsible- QIDP	

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W 263	Continued From page 4 When asked, the Administrator stated during an interview on 7/15/10 from 9:00 - 10:00 a.m., the restraint had been used and consent had not been obtained due to an oversight. The facility failed to ensure guardian consent for Individual #1's restraint was obtained prior to its use. Repeat Deficiency.	W 263		

Bureau of Facility Standards

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MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194	**MM194 16.03.11.075.10(a) APPROVAL OF HUMAN RIGHTS COMMITTEE** Refer to W262	
MM196	16.03.11.075.10(c) Consent of Parent or Guardian Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196	**MM196 16.03.11.075.10(c) CONSENT OF PARENT OR GUARDIAN** Refer to W263	
MM428	16.03.11.120.10(c) Tempeature of hot water The temperature of hot water at plumbing fixtures used by the residents must be between one hundred five (105) to one hundred twenty (120) degrees Fahrenheit. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure hot water temperatures were maintained between 105 and 120 degrees Fahrenheit for 6 of 6 individuals (Individuals #1 - #6) residing at the facility. The findings include: 1. During an environmental review at the facility on 7/13/10 from 11:55 a.m. - 12:33 p.m., the following water temperatures were found to exceed 120 degrees Fahrenheit: Kitchen sink: - 125 degrees.	MM428	**MM428 16.03.11.120.10(c) TEMPERATURE OF HOT WATER** To ensure hot water temperatures are maintained between 105 and 120 degrees Fahrenheit the maintenance man did re-set to acceptable temperature and will add a safety lock box to temperature control device to ensure that only the maintenance man would have access to adjusting the future water temperatures. Completed by 8-13-2010 Monitored- Monthly Person Responsible- House RSC and PCH Maintenance Man	

Bureau of Facility Standards

Kathy Kopke — Administrator — 7-30-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Bureau of Facility Standards

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MM428	Continued From page 1 Bathroom sink used by Individuals #1, #2, and #6: - 123.4 degrees. Bathroom sink used by Individuals #3 - #5: - 124.7 degrees. Medication Room sink: - 123 degrees. Present staff were immediately notified of the temperatures and proceeded to call the facility's maintenance man. The RSC, who was present, stated staff would ensure individuals had stand-by assistance until the temperatures dropped to an acceptable range. The maintenance man arrived at 12:15 p.m., and showed the surveyor the new "water on demand" system. It was noted the temperature was set at 130 degrees. The maintenance man re-set the system to an acceptable temperature and then informed the Administrator of the need for a plan to ensure the system was not readjusted or tampered with. The facility failed to ensure hot water temperatures were maintained between 105 and 120 degrees Fahrenheit.	MM428		
MM732	16.03.11.270.01(d)(iii) Date Objective Achieved Time limited, giving dates when the objective is to be achieved. This Rule is not met as evidenced by: Refer to W230.	MM732	**MM732 16.03.11.270.01(d)(iii) DATE OBJECTIVE ACHIEVED** Refer to W230	